Retiree Benefits

Retiree Benefits

Benefits for Retirees

Introduction

This section focuses on the benefits that are available to you in retirement. It is designed to provide useful, decision making information to all eligible participants of the state insurance program who are either considering retirement or have already retired. For more detailed information on the various benefits programs, please refer to the previous chapters of this guide. If you have any questions or need additional information, contact EIP via our Web site at www.eip.sc.gov or call EIP at 803-734-0678 or toll-free at 888-260-9430.

Retiree Insurance Eligibility Requirements

Retirees **from employers that participate in the state insurance program** are eligible for insurance coverage if they meet one or more of the following requirements and retire:

- due to years of service with the state; or
- due to age; or
- on approved disability through the South Carolina Retirement Systems (SCRS); or
- on approved Basic Long Term Disability and/or Supplemental Long Term Disability.

The rules are divided into two categories: eligibility for funded and non-funded insurance benefits.

Please note that each local subdivision (a public entity in South Carolina that falls within one of the categories established by Section 1-11-720 of the 1976 S.C. Code of Laws, such as counties, municipalities, regional tourism promotion commissions, county disability and special needs boards, regional councils of government, regional transportation authorities and alcohol and other drug abuse planning agencies) **sets its own guidelines for funding retirees. Local subdivision employees should contact their benefits office for information concerning retiree insurance premiums.**

Funded retirees:

Funded retirees are those retirees who are eligible for the state contribution to their retiree insurance premiums and who meet one of the following guidelines:

- Employees who are eligible to retire and have 10 or more years[1] of earned South Carolina Retirement Systems (SCRS) service credit with a participating state insurance program employer. Non-qualified, federal, military, out-of-state and service with employers that do not participate in the state insurance program do not count toward your 10 years eligibility requirement.
- Employees who leave employment before they are eligible to retire but have 20 or more years[1] of earned SCRS service credit with an employer that participates in the state insurance program. Non-qualified, federal,

military, out-of-state and service with employers that do not participate in the state insurance program do not count toward your 10 years eligibility requirement.

- Employees who left employment prior to 1990 that were not of retirement age, but who had 18 years of earned SCRS service credit with an employer that participates in the state insurance program, returned to work with a state-covered group, enrolled in a state health and dental plan; and worked for at least two consecutive years in a full-time, permanent position. Non-qualified, federal, military, out-of-state and service with employers that do not participate in the state insurance program do not count toward your 10 years eligibility requirement.

Non-funded retirees:

Non-funded retirees are those retirees that do not qualify for funded benefits (see previous rules) and who must pay the full premium cost (includes retiree share plus state contribution). Non-funded retirees include:

- Employees who retire at age 55 with at least 25 years[1] of retirement service credit (including at least 10 years of earned service credit with an employer that participates in the state insurance program). Non-qualified, federal, military, out-of-state and service with employers that do not participate in the state insurance program do not count toward your 10 years eligibility requirement. You must pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. Although sick leave may increase service credit under SCRS, retirees must pay the entire premium until age 60 or until they reach the date they would have had 28 years of service credit if they had continued working. At the end of this period you will be eligible for funded retiree rates. This rule does not apply to Police Officers Retirement System, General Assembly Retirement System and Judicial Retirement System participants.
- Employees who are eligible to retire and have at least five but less than 10 years[1] of earned SCRS service credit with a participating state insurance program employer.
- General Assembly members who leave employment before they are eligible to retire who have eight years of General Assembly Retirement System service credit.
- Former municipal and county council members who served on council for at least 12 years and were covered under the state's plans when they left the council. It is up to the county or municipal council to decide whether or not to allow former members to have this coverage.
- "Buy-in" retirees with at least 10 years[1] (non-qualified, federal, military, out-of-state and service with employers that do not participate in the state insurance program do not count toward your 10 years eligibility requirement) of earned retirement service credit with a participating state insurance program employer and who, prior to Jan. 1, 2001, established "buy-in" service credit. You must pay the full insurance premium for the "buy-in" period or to age 60, whichever occurs first. At the end of this period, you will be eligible for funded retiree rates. If you refuse insurance

coverage during your "buy-in" period, you must enroll within 31 days of the end of the "buy-in" period or late entry rules will apply. If you enroll before the end of the "buy-in" period, you will then pay the full premium for the remainder of the "buy-in" period or until you reach age 60, whichever occurs first. Then, you will be eligible for funded retiree rates. This rule does not apply to the "non-qualified service" purchase that was effective Jan. 1, 2001.

[1]Your last five years of employment must have been consecutive and in a full-time, permanent position with an employer that participates in the state insurance program. The additional service credit for unused sick leave may not be used to qualify for retirement or retiree insurance.

TERI

A Teacher and Employee Retention Incentive program (TERI) participant is retired for retirement benefit purposes only. For insurance benefits purposes, a program participant is considered an active employee, retaining all other rights and benefits of an active employee. Therefore, if you are a TERI program participant in a permanent, full-time position, your insurance benefits as an active employee should continue until your TERI period ends or you become ineligible as an active employee. When your active insurance benefits end, you should file for continuation as a retiree (if eligible) within 31 days of termination. your service as a TERI participant in a full-time, permanent position with a participating insurance program employer may be applied toward retiree insurance eligiblity.

Any covered subscriber who loses coverage and does not meet any of these rules may still be eligible for coverage continuation under COBRA (see Page 40).

How to Enroll

Eligible retirees must enroll by filing a Retiree Notice of Election (RNOE) within 31 days of their retirement date or within 31 days of approval for disability retirement or Long Term Disability benefits or within 31 days of a special eligibility situation. **Coverage is not automatic.** You may enroll yourself and any eligible dependents. Those enrolling who have had a break in health coverage for more than 62 days will be subject to pre-existing condition exclusions for 12 months.

If you and/or your dependents are not covered by a state health plan at the time of your retirement, you may enroll within 31 days of your retirement date or within 31 days of a special eligibility situation. You will be subject to pre-existing limitations for 12 months.

Late Entrant

If you and/or your dependents do not enroll within 31 days of retirement, disability approval or a special eligibility situation, you may enroll during an open enrollment period held every odd year (e.g., October 2005) as a late entrant. Your coverage will take effect the following January 1 (e.g., Jan. 1, 2006), but, as a late entrant, your coverage will be subject to a pre-existing condition exclusion for 18 months.

Your Health Plan Choices

Not entitled to Medicare

If you and your covered dependents are not entitled to Medicare, you may choose to be covered under one of the following:

- The SHP Economy plan;
- The SHP Standard plan;
- An HMO offered in your service area (See Page 47 for service areas);
- TRICARE Supplement plan.

Your health benefits will be the same as if you were an active employee. Refer to the previous chapters of this guide for benefit details.

Entitled to Medicare

If you and/or your covered dependents are entitled to Medicare, you may choose to be covered under one of the following:

- The SHP Standard plan;
- The SHP Medicare Supplemental plan;
- An HMO offered in your service area (See Page 47 for service areas).

This section will provide details on these benefits available to you. Please note that if you and/or your covered dependents are entitled to Medicare, the SHP Economy plan, MUSC Options and TRICARE Supplement are not available.

When Your Coverage as a Retiree Begins

If you go directly from active employment into retirement, retiree coverage will begin on your retirement date if you retire on the first of the month. Otherwise, retiree coverage will begin the first of the month following your retirement date; in the interim, your coverage as an active employee, if applicable, remains in effect. If you are enrolling due to a special eligibility situation, your effective date will be the date of the qualifying event or the first of the month following the qualifying event. If you enroll during an open enrollment your coverage will be effective the following January 1, unless otherwise specified.

Retiree Premiums and Premium Payment

State Agency and School District Retirees
Your health, dental, Dental Plus and Long Term Care premiums are deducted from your SCRS monthly retirement check. If the total premiums exceed the amount of your check, EIP will bill you directly for the full amount, or you may request a bank draft.

Local Subdivision Retirees
You pay your health, dental, Dental Plus and Long Term Care premiums directly to your former employer. That employer decides whether you must pay all or any portion of the employer share of the premiums. Contact your benefits office for information concerning your insurance premiums at retirement.

Your Insurance Identification Card in Retirement

Keep your identification card if you do not change plans when you retire. You and your covered dependents will not receive new ID cards at retirement if you remain covered under any SHP option, the State Dental Plan and Dental Plus. You will receive a new health identification card if you are changing from an HMO to any SHP option or vice versa and/or if you enroll in the State Dental Plan or Dental Plus for the first time. If your card is lost, stolen or damaged, you may request a new card from EIP or directly from the following (contact information is on Page215):

- State Health Plan — BlueCross BlueShield of South Carolina;
- HMO/POS — CIGNA HealthCare, Companion HealthCare or MUSC Options;
- Dental Plus — BlueCross BlueShield of South Carolina

Almost all insurance plans use some form of your Social Security number as your identification. For example, the SHP uses your Social Security number, but also includes the letters, "ZCS" in front of the number to identify you as a subscriber of the SHP's Economy, Standard, or Medicare Supplemental plan.

Covering Dependents

For information on adding and covering dependents (spouse and children), as well as eligibility requirements for dependents, refer to Pages 7 through 9 and Pages 68 through 70.

Decreasing Coverage

You may decrease your coverage level for health and dental if a spouse or dependent child becomes ineligible (spousal divorce or separation, child is 19 or older and is no longer a full-time student, child turns age 25, child marries or becomes employed with benefits). Changes should be requested within 31 days of ineligibility.

When Coverage Ends

Coverage Termination

Your SHP coverage will end:

- the day following your date of death;
- the date the SHP is terminated for all employees and retirees; or
- if you do not pay the required premium when it is due. (For example; if you are on leave without pay or on COBRA and are paying full cost, you must make a monthly payment.)

Dependent coverage will end:

- the date your coverage ends;
- the date dependent coverage is no longer offered by the SHP; or
- the last day of the month your dependent is no longer eligible for coverage.

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree or survivor, or under COBRA (see Page 40). If you are dropping a dependent from your coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

Death of an Retiree

In the event of the death of a retiree, you as a surviving family member should contact EIP to report the death, terminate the retiree's health coverage and initiate survivor coverage (if applicable). See Page 41 for more information on survivor coverage.

When You Or Your Dependents Become Entitled to Medicare

About Medicare

Medicare has two parts—*Part A* and *Part B*. Part A is your hospital insurance. Most people do not pay a premium for Part A because they or their spouse paid Medicare taxes while working. Part A helps cover your inpatient care in hospitals, critical access hospitals in rural areas and skilled nursing facilities. It also covers hospice care and some home health care. You must meet certain conditions to be eligible for Part A. Contact Medicare for additional information.

Medicare Part B is your medical insurance. Most people do pay a premium through the Social Security Administration for Part B. It helps cover doctors' services and outpatient hospital care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists and home health care. Part B pays for these covered services and supplies when they are medically necessary.

It is important to be enrolled in Part B if you are covered as a retiree or a dependent of a retiree because the State Health Plan will be the secondary payer and will coordinate benefits as if Medicare Part B has paid.

Medicare guarantees you coverage, regardless of health, if you are eligible. There are no pre-existing conditions, limitations or exclusions.

The Medicare + Choice program was created by the *Balanced Budget Act* of 1997. Individuals may now choose from a number of new health plan options in addition to Part A and Part B under the original Medicare program. Types of plans available, depending upon availability in your area, may include health maintenance organizations (HMOs), HMOs with Point of Service options, preferred provider organizations, provider sponsored organizations, etc. You must have Medicare Part A and Part B to join a Medicare + Choice plan. These additional plan options are not addressed in this publication. Call Medicare or visit the Medicare Web site (see below) for additional information. To find out more about Medicare:

- Visit the Medicare Web site at **www.medicare.gov**;
- Call 1-800-MEDICARE (1-877-486-2048 TTY).

At Age 65

You should be notified of Medicare entitlement by the Social Security Administration three months in advance of reaching age 65 or at the time of entitlement due to disability. If not, contact your local Social Security office. If you are already receiving Social Security benefits when you turn 65, Medicare Part A and Part B start automatically. If you're not receiving Social Security, you should sign up for Medicare close to your 65th birthday, even if you aren't ready to retire.

If You Are an Active Employee

If you're actively working and/or covered under a state health plan for active employees, you do not need to sign up for Part B because your insurance as an active employee remains primary while you are actively working. However, if you

are planning to retire within three months of age 65, you should contact Social Security concerning your enrollment options. Keep in mind that when you subsequently retire you should sign up for Part B within 31 days of retirement as Medicare becomes your primary coverage in retirement.

If You Are a Retiree

If you are entitled to Medicare due to reaching age 65, EIP will notify you three months in advance of your 65th birthday so you may decide whether to change to the Medicare Supplemental plan, retain the Standard plan or one of the health maintenance organizations available in your service area. Remember, if you are entitled to Medicare, the SHP Economy plan is not available.

Medicare Before Age 65

If you are entitled to Medicare due to disability before age 65, **you must notify EIP within 31 days of Medicare entitlement** to be advised of your options and to receive coordination of benefits with Medicare. Should you become entitled to Medicare prior to age 65, you must notify EIP immediately.

Sign up for Medicare!

You must enroll in both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. **You should enroll in Medicare Part B if you are covered through the retiree group since these plans will coordinate with Part B benefits regardless of your Medicare status.**

Your Plan Choices

When you and/or your eligible dependents are covered under retiree group health insurance and become entitled to Medicare, **Medicare becomes the primary payer,** and your options change. The state offers you and your eligible dependents a choice between two SHP options—the *Standard* plan or the *Medicare Supplemental* plan. *If you choose the Medicare Supplemental plan, the person(s) without Medicare will have claims paid through the Standard plan's provisions.* If you prefer, you may select an HMO if available in your area, to meet a variety of health care needs. Contact the HMO for information.

TRICARE for Life

If you are a military retiree or an eligible spouse or dependent of a military retiree and you have Medicare Part B, you should also be entitled to TRICARE For Life. TRICARE For Life acts as a supplemental insurance to Medicare. If you have other insurance such as the SHP, TRICARE For Life will be the third payer after Medicare and the SHP. Please review your benefits under TRICARE For Life versus the SHP. For more information call TRICARE at 888-343-5433. If you have TRICARE For Life and wish to drop your SHP coverage, you should notify EIP to request a NOE form or submit a written request of cancellation. Please note that the TRICARE Supplement plan is no longer available if you are entitled to Medicare.

How Medicare Assignment Works

Under Medicare assignment, the Medicare subscriber agrees to have Medicare's share of the cost of services paid directly ("assigned") to a provider. Participating providers have agreed to submit all their Medicare claims on an assigned basis. Non-participating providers may choose whether to accept assignment on each individual claim. If you receive services from a non-participating physician, ask if he will accept assignment.

Doctors and suppliers have the opportunity each year to participate in the Medicare program. Those that participate will always accept the Medicare-approved amount as payment in full. Some doctors choose to accept assignment, some do not. If a doctor does not accept assignment, you may end up paying more for his or her services.

If a doctor decides to participate, the contract is good all year (the doctor cannot decide in the middle of the year to no longer participate). Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

The SHP in retirement

This section explains the key distinctions of the SHP in retirement. If you and/or your covered dependents are not entitled to Medicare, the state offers you and your eligible dependents a choice between two SHP options—The *Standard plan* or the *Economy plan*. Refer to the SHP section of this guide for a more complete overview of the benefits offered under these two plans.

Once you and/or your covered dependents become entitled to Medicare, the SHP offers the Standard and the Medicare Supplemental plans, which are outlined in the two next sections. The Economy plan is no longer available to you.

The SHP Standard Plan

The SHP Standard plan carries worldwide coverage and requires Medi-Call approval for inpatient hospital admissions; all maternity benefits (must call in the first trimester); outpatient surgical services in a hospital or clinic; the purchase or rental of durable medical equipment; and skilled nursing care, hospice care and home health care. You must also call APS Healthcare, Inc., administrator for the SHP's Mental Health and Substance Abuse benefits, for preauthorization before you receive mental health or substance abuse care.

The plan has both deductibles and coinsurance. Once you become entitled to Medicare, the Standard plan uses a carve-out method of claims payment.

How the SHP's Standard Plan Works Together With Medicare

SHP Hospital Network

When you are entitled to Medicare, Medicare is the primary payer and you may go to any hospital you choose. Medicare limits the number of days it will cover for hospital stays. If you are enrolled in the Standard plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the SHP network or BlueCard Program so that you will not be charged more than what the Standard plan allows. *Note: Mental health and substance abuse services are covered only at APS Healthcare, Inc., participating facilities.*

You must also call Medi-Call for approval of any additional inpatient hospital days and for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

SHP Physician Network

You may want to note that while you are not generally covered outside the United States under Medicare, you have worldwide coverage as part of the BlueCard Program under the SHP's Standard plan.

Using Medi-Call as a Retiree

Medicare has its own utilization review program. However, you will still need to call Medi-Call when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside of the state or country), and for extended care services such as skilled nursing facilities, private duty nursing, home health care, durable medical equipment and Veterans Administration hospital services. *Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call Medi-Call.*

Private Duty Nursing If You Have Medicare

Medicare does not cover private duty nursing; however, the SHP Standard plan does. The standard coinsurance rate applies for approved charges. Remember to call Medi-Call for private duty nursing services.

When Traveling Outside of South Carolina

If you are admitted to a hospital outside of the state or country as a result of an emergency, notify Medi-Call and follow the BlueCard guidelines.

Mental Health and Substance Abuse: Using APS As a Retiree

If you are entitled to Medicare and covered under the Standard plan, you must call APS Healthcare, Inc. (APS), administrator of the SHP Mental Health and Substance Abuse benefit, at 800-221-8699 for approval of inpatient hospital stays. Precertification and continued stay authorizations by APS are required for inpatient care. To receive benefits, you must use an APS network provider. Note: *Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must also call to register with APS and use an APS network provider.*

Prescription Drug Program

Medicare does not provide coverage for prescription drugs, except in a few cases, like certain cancer drugs. The Standard plan covers prescription drugs when purchased from a participating pharmacy. Please refer to Pages 28-31 for more information on the SHP Prescription Drug Program.

Ambulatory Surgical Center Network

If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a center that participates in the network.

Transplant Contracting Arrangements

As part of this network under the SHP, you have access to the leading transplant facilities in the nation, including instate providers of transplant services. If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a facility that participates in the network.

Mammography Testing Benefit

The SHP allows female subscribers ages 35-74 to have routine mammograms—one baseline mammogram if you are age 35-39, one routine mammogram every other year if you are age 40-49 and one routine mammogram every year if you are age 50-74—at no cost if you use a facility that participates in the program's network.

Medicare allows yearly routine mammograms for women age 40 and older and pays 80 percent of Medicare-approved charges. Check with the testing facility to see if it accepts Medicare assignment.

Pap Test Benefit

The SHP will pay for yearly Pap tests for covered women ages 18-65. The Pap test benefit applies whether or not the Pap test is routine or diagnostic. The deductible and coinsurance do not apply to this benefit. This benefit does not include the doctor's office visit or other lab tests. Medicare covers a Pap test, pelvic exam and clinical breast exam every other year (yearly, if you are at high risk. Check with Medicare for more information). Medicare pays 100 percent for the test; 80 percent for the exam and collection.

Maternity Management & Well Child Care Benefits

The SHP offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be covered by the SHP receive necessary prenatal care. (This benefit applies to covered retirees and spouses; it does not apply to dependent children). The Well Child Care benefit offers coverage for routine check-ups and immunizations of children through age 12. Medicare does not provide similar coverage. Refer to Pages 23 and 24 for more information on these benefits.

"Carve-out" Method of Claims Payment

The Standard plan coordinates with Medicare on the basis of the SHP-approved charge. The carve-out method of claims payment works just like coordination of benefits with any other plan when an individual is covered by two insurance plans—one pays first and the other pays second. If your provider accepts Medicare assignment, the Standard plan will pay the lesser of:

1. The Medicare-allowed amount less the Medicare-reported payment; or
2. The SHP-allowed amount less the Medicare-reported payment.

If your provider does not accept Medicare assignment, the Standard plan pays the difference between the SHP's allowable amount and the amount Medicare reported paying. If the Medicare payment exceeds the SHP's allowable amount, the Standard plan will not pay a benefit. The Standard plan will never pay for charges that are more than the SHP's allowable amount. With the Standard plan, your total benefits (Medicare plus the SHP) will be equivalent to those offered to active employees and retirees not entitled to Medicare.

Example:
Hospital bill for a January admission is $7,500:

$7,500	Hospital bill
- 876	Medicare Part A deductible for 2004
$6,624	Medicare payment
$ 876	You pay (unless you have another health insurance plan)

If services are provided in South Carolina, the claim will be sent automatically to the SHP. If services are provided outside South Carolina, you will need to send the Explanation of Medicare Benefits (EOMB) to BlueCross BlueShield of South Carolina. If the claim is for mental health or substance abuse services, whether provided inside or outside South Carolina, you will need to send the EOMB to APS Healthcare, Inc.

If you are enrolled in the Standard plan your claim will be processed like this:

$7,500	Hospital bill
- 350	Standard plan deductible for 2004
7,150	Standard plan liability
x 80%	Standard plan coinsurance
$5,720	Amount the plan would pay in the absence of Medicare
- 6,624	Amount paid by Medicare
$ -0-	Standard plan pays nothing, you pay the lesser of 20 percent or balance of bill*

**You pay the 20 percent coinsurance or the balance of bill, whichever is less. In this example, your 20 percent coinsurance of $1,430, plus the $350 deductible, is $1,780; however, the balance of the bill is only $876, so you pay $876. Once you reach your $2,000 coinsurance maximum, all claims will be allowed at 100 percent of the allowable charge based on the carve-out method of claims payment. All Medicare deductibles and Medicare Part B 20 percent coinsurance should be paid-in-full for the rest of the calendar year after you reach your $2,000 coinsurance maximum.*

Filing Claims As a Retiree

Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the SHP for you. Your mental health and substance abuse provider should file claims for you with APS, including Medicare payment information. If you or your doctor have not received payment or notification from the SHP within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina (BCBSSC), claims administrator for the SHP, a claim form and a copy of your Explanation of Medicare Benefits with your SHP subscriber identification number written on it.

Claims Filed Outside South Carolina

If you receive services outside of South Carolina, your provider will file the claim to the Medicare carrier in that state. When you receive your Explanation of Medicare Benefits, you must send it to BCBSSC for medical or surgical services or APS for mental health or substance abuse services along with a claim form and itemized bill.

If Medicare Denies Your Claim

If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim to BCBSSC. You may use the same SHP claim form as active employees do. These forms are available from EIP or BCBSSC. You will need to attach your Explanation of Medicare Benefits and an itemized bill to your claim form.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits from them, mail it, along with an itemized bill and claim form, to BCBSSC for processing.

The Medicare Supplemental Plan

You may enroll in this plan when you retire or during a designated enrollment period for the Medicare Supplemental plan. If you are enrolled in a health plan, you may change to the Medicare Supplemental plan within 31 days fo entitlement to Medicare. Designated Medicare Supplemental plan enrollment periods are held every other October on the odd year (2005). During this time, you can change from the Standard plan to the Medicare Supplemental plan or vice versa. Plan changes are effective on the first of January following the enrollment period.

This section explains the SHP Medicare Supplemental plan, which is available to retirees and covered dependents who are entitled to Medicare.

General Information

The Medicare Supplemental plan is similar to a Medigap policy—it fills the "gap" or pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental plan adheres to Medicare-approved charges. If your medical provider does not accept Medicare assignment, and charges you more than what Medicare allows, you pay the difference.

Medicare Deductibles and Coinsurance

Deductibles

Medicare Part A has an inpatient hospital deductible for each benefit period. That deductible is $87 6 for 2004. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. *The Medicare Supplemental plan pays the Part A deductible.*

Medicare Part B has a deductible of $100 per year. Part B also includes a monthly premium of $66.60 for 2004 and covers physician services, supplies and outpatient care. As a retiree, you should enroll in Part B as soon as you are entitled to Medicare, as Medicare becomes primary. *The Medicare Supplemental plan pays the Part B deductible.*

Coinsurance

Medicare Part B pays 80 percent of Medicare-approved charges (50 percent for outpatient mental health care). *The Medicare Supplemental plan pays the remaining 20 percent (50 percent for outpatient mental health care).*

Medicare Supplemental Plan Deductibles and Coinsurance

The Medicare Supplemental plan benefit period is from January 1 - December 31 and includes a $200 deductible each calendar year that applies to private duty nursing services only. If you become entitled to Medicare and change to the Medicare Supplemental plan during the year, you must meet a new $200 deductible for private duty nursing services. You do not have to meet another $200 deductible for private duty nursing services if you retain the Standard plan.

What the Medicare Supplemental Plan Covers

Hospital Admissions

The Medicare Supplemental plan pays the following benefits for Medicare-covered services after Medicare Part A benefits have been paid during a benefit period:

- The Medicare Part A hospital deductible;
- The coinsurance, after Medicare pays, for days 61-150 of hospitalization, up to the Medicare-approved charge (Medicare pays 100 percent for the first 60 days);
- 100 percent of Medicare-approved charges for hospitalization beyond 150 days, if medically necessary (Medicare does not pay beyond 150 days)*;
- The coinsurance for durable medical equipment up to the Medicare-approved charge*.

**Must call Medi-Call for approval.*

Skilled Nursing Facilities

The Medicare Supplemental plan will pay the following benefits after Medicare has paid benefits during a benefit period:

- The coinsurance, after Medicare pays, up to the Medicare-approved charge for days 21-100 (Medicare pays 100 percent for the first 20 days);
- 100 percent of the Medicare-approved charges beyond 100 days in a skilled nursing facility if medically necessary (Medicare does not pay beyond 100 days).* The maximum benefit per year is $6,000.

**Must call Medi-Call for approval.*

Physician Charges

The Medicare Supplemental plan will pay the following benefits related to physician services approved by Medicare:

- The Medicare Part B deductible;
- The coinsurance of the Medicare-approved charge for physician's services for surgery, necessary home and office visits, in hospital visits and other covered physician's services;
- The coinsurance for Medicare-approved charges for physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.

Home Health Care

The Medicare Supplemental plan will pay the following benefits for medically necessary home health care services:

- The Medicare Part B deductible;
- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent for Medicare-approved charges), up to 100 visits or $5,000 per benefit year, whichever occurs first.

The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the covered person.

Private Duty Nursing Services

Private services provided by a registered nurse (RN) or a licensed practical nurse (LPN) that have been certified in writing by a physician as medically necessary. There is a $200 annual deductible that applies, regardless of the time of year

you enroll in the plan. This service is NOT covered by Medicare. Once the deductible is met, the Medicare Supplemental plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is $5,000. The lifetime maximum benefit under the Medicare Supplemental plan is $25,000.

Prescription Drugs

Although Medicare does not provide coverage for prescription drugs, except in a few cases, like certain cancer drugs, the Medicare Supplemental plan covers prescription drugs when purchased from a participating pharmacy under the SHP's Prescription Drug Program, administered by Medco Health Solutions, Inc. For more information, refer to Pages 28-31.

Diabetic Supplies

Medicare covers some diabetic supplies for people with Medicare with diabetes (insulin users and non-insulin users). These include limited quantities of:

- blood glucose test strips (**Important Note:** Effective April 1, 2002, all Medicare enrolled pharmacies and suppliers must submit claims for glucose monitor test strips. You cannot send in the claim for glucose test strips yourself.),
- blood glucose meter,
- lancet devices and lancets, and
- glucose control solutions for checking the accuracy of test strips monitors.

For more information on how Medicare covers diabetic supplies, go to Medicare's Web site at www.medicare.gov.

Hospital Visits

If you are entitled to Medicare, Medicare is the primary payer, and you may go to any hospital you choose. However, Medicare limits the number of days it will cover you for hospital stays—Medicare pays nothing for hospital stays beyond 150 days.

If You Exceed the Number of Inpatient Hospital Days Allowed Under Medicare: If you are enrolled in the Medicare Supplemental plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call for approval of any additional inpatient hospital days. If your extended stay is approved, the Medicare Supplemental plan will pay for the Medicare-approved expenses. So, if you are enrolled in the Medicare Supplemental plan and you expect your hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP network or BlueCard program so that any additional days beyond what Medicare allows will be covered by the Medicare Supplemental Plan. *Note: Mental health and substance abuse services are covered at APS Healthcare, Inc., participating facilities.*

You must also call Medi-Call for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

When Traveling Outside the United States

Although the SHP hospital network also includes participating hospitals across the country and around the world through the BlueCard Program, administered by BlueCross BlueShield of South Carolina, Medicare does not cover services outside the United States. Since the Medicare Supplemental plan

does not allow benefits for services not covered by Medicare (other than prescription drugs and private duty nursing), the BlueCard Program does not apply to Medicare Supplemental plan subscribers.

Using Medi-Call

Medicare has its own utilization review program. You will need to call Medi-Call only when Medicare benefits are exhausted for inpatient hospital services and for extended care services such as skilled nursing facilities, private duty nursing, home health care, durable medical equipment and Veterans Administration hospital services. *Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call Medi-Call.*

Mental Health & Substance Abuse

If your claims are processed under the Medicare Supplemental plan, you do not need to call APS, administrator of the SHP Mental Health and Substance Abuse benefit, because Medicare guidelines will apply. However, if you exhaust Medicare's allowed inpatient hospital days, you must call APS for approval of any additional inpatient hospital days. Precertification and continued stay authorizations from APS are required for inpatient care; however, you are not required to use an APS network provider. *Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call to register with APS and use an APS network provider.*

Ambulatory Surgical Center Network

The Ambulatory Surgical Center Network includes facilities throughout the state that provide some of the same services as provided in the outpatient departments of hospitals. These centers accept the SHP's allowed charges and will not charge you more. If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a center that participates in the SHP network.

Transplant Contracting Arrangements

As part of this network under the SHP, you have access to the leading transplant facilities in the nation, including instate providers of transplant services. If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a facility that participates in the SHP network.

Mammography Testing Benefit

If you are entitled to Medicare, Medicare allows yearly routine mammograms for women ages 40 and older and pays 80 percent of the Medicare-approved amount. The Medicare Supplemental plan pays the 20 percent coinsurance.

Pap Test Benefit

If you are entitled to Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every other year (yearly, if you are at high risk. Check with Medicare for more information). Medicare pays 100 percent for the Pap lab test; 80 percent of the Medicare-approved amount for the Pap test collection and the pelvic and breast exam. The Medicare Supplemental plan pays the 20 percent coinsurance.

Please note that the Medicare Supplemental plan will pay for Pap tests for covered women, ages 18-65, *every year,* so you may take advantage of this benefit in the years that Medicare does *not* pay. The Pap test benefit applies whether or not the Pap test is routine or diagnostic. The deductible and coinsurance do not

apply to this first-dollar benefit. This benefit does not include the doctor's office visit or other lab tests.

Maternity Management & Well Child Care Benefits

The Medicare Supplemental plan offers benefits geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be covered by the SHP receive necessary prenatal care. (This benefit applies to covered retirees and spouses; it does not apply to dependent children). The Well Child Care benefit offers coverage for routine check-ups and immunizations of children through age 12. If you are entitled to Medicare, you may want to know that Medicare does not provide similar coverage. Refer to Pages 23 and 24 for more information on these benefits.

Medicare Assignment

If the provider accepts Medicare assignment (assigned claims), the provider accepts Medicare's payment plus the Medicare Supplemental plan's payment as payment in full. If the provider does not accept Medicare assignment (non-assigned claim), the provider may charge more than what Medicare and the Medicare Supplemental plan pay combined. You would pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500 Hospital bill
- 876 Medicare Part A deductible for 2004
$6,624 Medicare payment

$ 876 You pay (unless you have another health insurance plan)

If services are provided in South Carolina, the claim will be sent automatically to the SHP. If services are provided outside South Carolina, you will need to send the Explanation of Medicare Benefits (EOMB) to BlueCross BlueShield of South Carolina. If the claim is for mental health or substance abuse services, whether provided inside or outside South Carolina, you will need to send the EOMB to APS Healthcare, Inc.

The Medicare Supplemental plan will pay all Medicare deductibles and coinsurance:

$ 876 Medicare Supplemental plan pays Medicare Part A deductible
+6,624 Amount paid by Medicare
$7,500 Bill paid in full

Filing Claims As a Retiree

If you are entitled to Medicare, Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed Inside South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to

the SHP for you. Your mental health and substance abuse provider should file claims to APS with Medicare payment information. If you or your doctor has not received payment or notification from the Plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina (BCBSSC), claims administrator for the SHP, a claim form and a copy of your Explanation of Medicare Benefits with your subscriber identification number written on it.

Claims for covered family members not entitled to Medicare but insured through the Medicare Supplemental plan are paid through the Standard plan provisions. The carve-out method does not apply to family members who are not entitled to Medicare.

Claims Filed Outside South Carolina

If you receive services outside of South Carolina, your provider will file its claim to the Medicare carrier in that state. When you receive your Explanation of Medicare Benefits, you must send it to BCBSSC for medical or surgical services or APS for mental health and substance abuse services along with a claim form and itemized bill.

If Medicare Denies Your Claim

If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim to BCBSSC. You may use the same SHP claim form that active employees do. These forms are available from EIP or BCBSSC. You will need to attach your Explanation of Medicare Benefits and an itemized bill to your claim form.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits from them, mail it, along with an itemized bill and claim form, to BCBSSC for processing.

HMO Plans in Retirement

This section explains some key distinctions of the health maintenance organizations (HMOs) and how they work together with Medicare. For a more complete overview of the plans, refer to the HMO section of this guide or contact the HMO.

Remember, you must live in an HMO or POS plan's service area to enroll. Not all HMOs or POS plans are available in all service areas. A list of service areas may be found on Page 47.

If You Are Entitled to Medicare

MUSC Options is **not** available if you or your covered dependents are entitled to Medicare. However, the Companion HMO, Companion-CHOICES POS and CIGNA HMO plans are available if you live in their service area. This section will focus on the latter three plans.

Provider Networks Traditional HMOs provide a list of participating network doctors from which you choose a primary care physician. This doctor coordinates your care, which means you must contact him to be referred to specialists who also participate within the HMO's network. Network providers file the claims for you. If you belong to an HMO, the plan covers only medical services received within its network of providers. If you receive care outside of the network, benefits are not paid. Typically, the only services you receive from out-of-network providers that most HMOs cover are those for emergency medical conditions.

A POS plan is an HMO plan that allows you to selectively go to a provider outside of its network. When you do so, you are likely to have much higher out-of-pocket expenses in the form of deductibles and copayments.

When Traveling Outside the Network or the U.S. When traveling outside the CIGNA or Companion networks, you will be covered for emergency medical care. If your insurance identification cards are not recognized by the treating hospital, you may be required to pay for the services, then later file a claim for reimbursement.

Prescription Drug Programs Medicare does not provide coverage for prescription drugs, except in a few , cases like certain cancer drugs. However, all HMOs and POS plans offered for 2004 include a prescription drug program with participating pharmacies.

How Companion HMO and Companion-CHOICES POS Work Together With Medicare

Companion HealthCare's (Companion) health maintenance organization (Companion HMO), with or without the Point of Service (Companion-CHOICES) option pays only Medicare-approved charges. Both supplement Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plans also pay the 20 percent coinsurance left after Medicare pays 80 percent for Part B-approved services.

These two plans pay the coinsurance days for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and the first 20 days of skilled nursing care). Companion also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment (assigned claims), the provider accepts Medicare's payment plus Companion's payment as payment in full. If the provider does not accept Medicare assignment (non-assigned claim), the provider may charge more than what Medicare and Companion pay combined. The subscriber would pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500 Hospital bill
- 876 Medicare Part A deductible for 2004
$6,624 Medicare payment

$ 876 You pay (unless you have another health insurance plan)

Companion pays all Medicare deductibles and coinsurance:

$ 876 Companion pays Medicare Part A deductible
+6,624 Amount paid by Medicare
$7,500 Bill paid in full

Additional information about the Companion plans is provided in the HMO section of this guide.

How CIGNA HMO Works Together With Medicare

CIGNA's HMO pays the lesser of the subscriber's unreimbursed allowable expense under Medicare or CIGNA's normal liability. If the balance due on the claim is less than the normal liability, then CIGNA will pay the balance due.

CIGNA's benefit credit saving provisions apply. A *benefit credit* is the portion of the payment that CIGNA does not have to pay out as part of its normal liability as a result of a coordination of benefits with Medicare. It may be applied as credit toward future claims within the calendar year. *Benefit credit saving* is the difference between CIGNA's normal liability and CIGNA's actual payment. Benefit credit saving applies only to the family member who incurs the charge, and it expires at the end of the calendar year in which it is gained. Contact CIGNA HealthCare for additional information.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500 Hospital bill
- 876 Medicare Part A deductible
$6,624 Medicare payment

$ 876 Balance due

If you are enrolled in CIGNA's HMO plan your claim will be paid like this:

$7,500 Hospital bill
- 250 CIGNA's inpatient per occurrence copayment
$7,250
x 90% CIGNA's coinsurance
$6,525 CIGNA's liability in absence of Medicare
- 876 Amount paid by CIGNA in coordination with Medicare

$5,649 Benefit credit savings with CIGNA

Filing Claims As a Retiree

If you are entitled to Medicare, Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

For more information, contact the HMO (see Page 215).

Dental Benefits

If you retire from a participating entity, you can continue your State Dental Plan and Dental Plus coverage, provided you meet the eligibility requirements (see Page 168). Coverage is not automatic. You must file a Notice of Election (NOE) with EIP within 31 days of your retirement date or date of disability approval to maintain continuous coverage.

If you are not eligible for retiree insurance, you must request COBRA continuation coverage within 60 days of loss of coverage or notification of the right to continue coverage, whichever is later.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period (October 2005) with a coverage effective date of the following January 1 (2006). You also may enroll within 31 days of a special eligibility situation. For information on the State Dental Plan and Dental Plus, see Pages 65-89.

Life Insurance

$3,000 Basic Life Insurance

This benefit is given to you as an active employee and *ends* with retirement or termination. You may convert the $3,000 Basic Life to an individual policy through The Hartford within 31 days of the date of coverage termination. Contact your benefits office or EIP for additional information and assistance.

South Carolina Retirement Systems (SCRS) Retiree Group Life Insurance

As a retiree, if you die and your last employer prior to retirement is covered by the Retiree Group Life Insurance program, a benefit based on your retirement credited service in the SCRS will be paid by the SCRS to your beneficiaries as follows:

SCRS	PORS
10-19 years service credit=$2,000	10-19 years service credit=$2,000
20-27 years service credit=$4,000	20-24 years service credit=$4,000
28 or more years service credit=$6,000	25 or more years service credit=$6,000

Optional Life Insurance

You are able to carry your Optional Life Insurance into retirement as follows:

- If you retired on or after Jan. 1, 2001, you may continue your coverage in $10,000 increments up to the final face value of coverage until age 75. At age 70, coverage is reduced for active employees and retirees.

- You may convert your Optional Life coverage to an individual policy.

Retiree coverage does not include the Living Benefit or Accidental Death, Seat Belt Rider and Dismemberment provisions. To continue your coverage, you must complete the required enrollment forms within 31 days of your date of retirement. If you are leaving employment due to a disability and are continuing Optional Life coverage under the 12 months waiver provision, you must file for continuation within 31 days of the end of the 12 months waiver. If you have questions about continuing your coverage as a retiree, contact your benefits office or EIP.

If you participate in the Teacher and Employee Retention Incentive (TERI) program, you should continue your benefits as an active employee, provided you are eligible. When the TERI period ends you should file for retiree benefits within 31 days as indicated above.

If you continue coverage as a retiree and return to active employment with a state-covered entity, you must choose whether to enroll in Optional Life insurance coverage as an active employee or to continue your retiree coverage. Participation in both programs is prohibited. Your active group coverage will become effective only if you terminate the retiree continuation coverage.

Premiums are on Pages 113-115.

Optional Life if You Become Disabled

If you become totally disabled while covered as an active employee, your life insurance will be continued for up to 12 months from your last day worked, provided:

- Your total disability began while you were covered by this Optional Life Insurance plan;
- Your total disability began before you reached age 69; and
- The group Optional Life Insurance policy does not end.

Your premiums will be waived for up to 12 months from the last day worked as long as you are totally disabled. The 12-month waiver period begins the first of the month following your last day worked. In order for your premiums to be waived, you must provide proof of disability to your benefits administrator within one year after the last day you were physically at work. If you return to work during the 12 months waiver period and work one full week, the premium waiver period should end; if you must leave employment again due to total disability, the 12 months waiver will start over from the last day you were physically at work.

When the waiver ends, you must file for continuation through The Hartford within 31 days of the waiver end date. Contact EIP for additional information.

Premium Pretax Feature and Accidental Death and Dismemberment benefits do not apply to retirees.

Dependent Life Insurance

Any Dependent Life Insurance coverage you may have will terminate when you terminate active employment. Your covered dependent may convert the insurance coverage to an individual policy. The dependent must apply to The Hartford in writing within 31 days of the termination date of coverage and pay the required premiums.

Long Term Disability

The general purpose of disability insurance is to protect an employee and the family against loss of income due to an extended injury or illness that prevents the employee from being able to work. In retirement, your income is guaranteed for your lifetime, and beyond, if you select a retirement annuity with a survivor option. When you terminate active employment, your Basic and Supplemental Long Term Disability will end.

Basic Long Term Disability

This benefit may not be continued or converted to an individual policy.

Supplemental Long Term Disability

Generally, you may not continue Supplemental Long Term Disability coverage in retirement. However, if you are retiring or leaving employment, but plan to work for an employer that does not have a supplemental long term disability program, contact the Employee Insurance Program for more information about continuing coverage through Standard Insurance Company, administrator for both the Basic and the Supplemental Long Term Disability programs.

Long Term Care

Long term care refers to a wide range of personal health care services for people of all ages who suffer from chronic conditions. These individuals often need custodial care rather than skilled care. Custodial care is assistance with the activities of daily living such as eating, toileting, dressing and transferring from a bed to a chair. This type of care can be provided in a nursing home, an adult daycare center or at home and is generally not covered under a health insurance plan.

Long Term Care Services Already Covered

Medicare covers some home health care and skilled nursing facility services; however, there are limits on the dollar amounts paid and the number of visits allowed. Neither the SHP nor Medicare covers custodial care services, and to qualify for Medicaid, you must exhaust most of your personal assets and income.

Continuing Coverage Into Retirement

If you are enrolled in LTC at the time you retire, you may continue your coverage. Each family member covered at the time of your retirement may continue coverage as well. You must elect to continue LTC coverage within 31 days of the date coverage would otherwise terminate.

Enrolling in Coverage at Retirement

You and/or your spouse/surviving spouse may enroll in LTC at any time by providing medical evidence of good health. You should request information and an application from Aetna or EIP. If you are approved for coverage, Aetna will send confirmation to you and to EIP.

Premiums

You pay the entire cost of LTC coverage for yourself and your spouse (if applicable). If you and your spouse choose to participate in the plan, your premiums will be based on your age at the time of your application (some exceptions may apply). Premiums may be found on Pages 212-214. EIP will deduct your premiums from your monthly SCRS annuity. However, if your pension benefit is not sufficient to cover the entire amount of your health, dental and LTC premiums, Aetna will bill you directly for LTC premiums. You may request in writing to have your premiums drafted automatically from your bank account. Local subdivision retirees will be billed by the local subdivision.

MoneyPlu$ is Not Available in Retirement

Vision Care Program

This benefit remains the same in retirement regardless of whether you are enrolled in the State Health Plan or a health maintenance organization or not. Please refer to Pages 159-163 for more information.

Returning to Work

Since the earnings limitation for service retirees of the South Carolina Retirement Systems has increased and the earnings limitation has been suspended for teachers in critical needs areas, more individuals are electing to receive their monthly retirement benefits while continuing to work. In addition, people who are already retired are returning to work.

Deciding on Coverage

If you are covered under the state retiree group and return to active employment in a permanent, full-time position, you must decide whether you want to be covered under the active group employee benefits or continue your retiree group benefits. You cannot be covered under both. If you prefer to continue your retiree group insurance benefits, you must complete and sign a refusal form

for active benefits. Keep in mind that if you refuse to enroll as an active employee, you are also refusing benefits that are available to active employees only:

- $3,000 Basic Life benefit;
- Basic and Supplemental Long Term Disability coverage;
- Dependent Life Insurance;
- Optional Life Insurance;
- MoneyPlu$ benefits.

If You Are Entitled to Medicare

If you are entitled to Medicare and return to active employee benefits, Medicare will become the secondary payer to the state group active coverage. Therefore, you must notify Social Security that you are covered under the active group coverage, and Medicare Part B may be dropped while you are covered as an active employee. When you leave active employment and your active group coverage is terminated, you will be eligible to return to retiree group coverage. You must file an enrollment form to return to the state retiree group. In addition, you should notify Social Security that you are no longer covered under an active group so that you can re-enroll for Medicare Part B.

TERI Program

How TERI Works

The Teacher and Employee Retention Incentive (TERI) program with the South Carolina Retirement Systems (SCRS) allows you to retire and begin accumulating your retirement annuity on a deferred basis without terminating your employment. By participating in the program, you may defer your retirement benefit for up to five years. Your monthly retirement annuity is deferred and accumulated in your TERI account. Upon termination of employment or at the end of your TERI period, whichever occurs first, you may receive the balance in your TERI account in either a taxable, lump-sum distribution or through a rollover into a qualified retirement plan. You will then begin receiving your monthly service retirement benefit plus any cost-of-living increases. No interest is paid on annuity benefits accumulated in your TERI account.

As a TERI participant you are technically retired. You do not make contributions to your SCRS account, nor do you earn service credit. You are also ineligible to receive active SCRS Group Life Insurance benefits or SCRS disability retirement benefits. During the TERI period, you are exempt from the service retirement earnings limitation. If you continue to work for a covered employer after your TERI period ends, you will be subject to the service retirement earnings limitation. For more information on the TERI program, contact SCRS.

How TERI Affects Your Insurance Coverage

If you are participating under the TERI program, you continue your insurance coverage under the active group insurance program as long as you are eligible. At the end of your TERI period, you will need to file for continuation of coverage as a retiree within 31 days.

Comparison of Health Plan Benefits for Retire

TYPE	PREFERRED PROVIDER ORGANIZATION To receive the higher level of benefits, subscribers should choose an in-network provider.		TRADITIONAL HMO All care must be directed by a prima approved by the HMO.
PLAN	**SHP ECONOMY PLAN**	**SHP STANDARD PLAN**	**COMPANION HMO**
SERVICE AREAS	◆ Coverage worldwide	◆ Coverage worldwide	◆ Service areas: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12
ANNUAL DEDUCTIBLE Single Family	 $500 $1,000	 $350 $700	 None
HOSPITALIZATION/EMERGENCY CARE	Outpatient hospital: $75 per-occurrence deductible Emergency care: $125 per-occurrence deductible	Outpatient hospital: $75 per-occurrence deductible Emergency care: $125 per-occurrence deductible	Inpatient: $200 copay Outpatient: $75 copay/first 3 visits Emergency care: $75 copay
COINSURANCE	**In-network** | **Out-of-network** Plan pays 75% | Plan pays 55% You pay 25% | You pay 45%	**In-network** | **Out-of-network** Plan pays 80% | Plan pays 60% You pay 20% | You pay 40%	HMO pays 90% after copays You pay 10%
COINSURANCE MAXIMUM	$2,000 $4,000 (excludes deductible)	$2,000 $4,000 (excludes deductible)	$1,500 $3,000 (excludes copays)
PHYSICIAN VISITS	$10 per visit deductible then: **In-network** | **Out-of-network** Plan pays 75% | Plan pays 55% You pay 25% | You pay 45%	$10 per visit deductible then: **In-network** | **Out-of-network** Plan pays 80% | Plan pays 60% You pay 20% | You pay 40%	$15 PCP copayment $15 OB/GYN well woman exam $25 specialist copay $35 urgent care copay
PRESCRIPTION DRUGS	Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): $23 generic, $56 preferred brand; $90 non-preferred brand Copayment Max: $2,500	Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): $23 generic, $56 preferred brand; $90 non-preferred brand Copayment Max: $2,500	Participating pharmacies only (Generics First): $7 generic $25 preferred brand $40 nonpreferred brand $75 specialty pharmaceuticals (31-day supply) Mail-order (up to 90-day supply): $21 generic; $75 preferred brand; $120 non-preferred brand No copayment Max
MENTAL HEALTH/ SUBSTANCE ABUSE	Participating providers only. Call 1-800-221-8699. Subject to above deductibles and coinsurance.	Participating providers only. Call 1-800-221-8699. Subject to above deductibles and coinsurance.	Participating providers only. Call 1-800-868-1032. Inpatient: $200 copay, then 90% covered; Outpatient: $25 specialist copay
LIFETIME MAXIMUM	$1,000,000	$1,000,000	$1,000,000

es and Dependents NOT Entitled to Medicare

	HMO WITH POINT OF SERVICE (POS) OPTION			
ry care physician (PCP) and	To receive the higher level of benefits, care must be directed by a primary care physician (PCP) and approved by the HMO. Medically necessary benefits are available out-of-network at a lower benefit level.			
	CIGNA HMO	**COMPANION-CHOICES POS**		**MUSC Options**	
	◆ Service areas: 1, 2, 3, 5, 7, 8, 9, 10, 11, 12	◆ Service areas: 1, 2		◆ Service area: 11	
		In-network	**Out-of-network**	**In-network**	**Out-of-network**
	None	None	$500 per individual	None	$300 $900
	Inpatient: $500 copay Outpatient facility: $250 copay Emergency care: $100 copay	Inpatient: $200 copay Outpatient Surgery: $75 copay/first 3 visits Emergency care: $75 copay	Inpatient: $250 copay Outpatient Surgery: $125 copay Emergency care: $75 copay	Inpatient: $300 copay Outpatient Facility: $100 copay Emergency care: $100 copay	Annual deductibles for inpatient and outpatient care Emergency care: $100 copay
	HMO pays 80% after copays You pay 20%	HMO pays 90% after copays; You pay 10%	HMO pays 70% after deductible and copays	HMO pays 100% after copays	HMO pays 60% of allowance You pay 40%
	$3,000 (includes inpatient, outpatient copays & coinsurance) $6,000	$1,500 $3,000 (excludes copays)	$3,000 $6,000 (excludes copays and deductible)	N/A	$3,000 $9,000 (excludes deductibles)
	$20 PCP copayment $40 OB/GYN well woman exam $40 specialist copay	$15 PCP copay $15 OB/GYN well woman exam $25 specialist copay $35 urgent care copay	Coinsurance: HMO pays 70% of allowance after annual deductible You pay 30%	$15 PCP copay $15 OB/GYN well woman exam $25 specialist copay with referral $45 specialist copay without referral	Coinsurance: HMO pays 60% of allowance after annual deductible You pay 40% No preventive care benefits out-of-network
	Participating pharmacies only: $10 generic $20 preferred brand $50 nonpreferred brand (30-day supply) Mail-order (up to 90-day supply): $20 generic; $40 preferred brand name; $100 non-preferred brand name No copayment Max	Participating pharmacies only (Generics First): $7 generic $25 preferred brand $40 nonpreferred brand $75 specialty pharmaceuticals (31-day supply) Mail-order (up to 90-day supply): $21 generic; $75 preferred brand name; $120 non-preferred brand name No copayment Max		Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (31 day supply) Mail-order available (90-day supply): $15 generic, $50 preferred brand, $80 non-preferred brand No copayment Max	
	Participating providers only. Inpatient: $500 copay, then 80% covered Outpatient: $40 specialist copay	Participating providers only. Call 1-800-868-1032. Inpatient: $200 copay, then 90% covered Outpatient: $25 specialist copay		Inpatient: $300 copay Outpatient: $25 copay with referral, $45 copay without referral	HMO pays 60%of allowance after annual deductible
	$1,000,000	$1,000,000		$1,000,000	

Comparison of Health Plan Benefits for Retirees

PLAN	PREFERRED PROVIDER ORGANIZATION		TRADITIONAL HMO
	SHP ECONOMY PLAN	SHP STANDARD PLAN	COMPANION HMO
INPATIENT HOSPITAL DAYS[1]	Plan pays 75% You pay 25% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 90% You pay 10% with $200 copay and coinsurance maximum
SKILLED NURSING CARE	Plan pays 75% You pay 25% up to $6,000 or 60 days, whichever is less (Medi-Call required)	Plan pays 80% You pay 20% up to $6,000 or 60 days, whichever is less (Medi-Call required)	Plan pays 90% You pay 10% up to 120 days
PRIVATE DUTY NURSING	Plan pays 75% You pay 25% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 90% You pay 10% up to 60 days
HOME HEALTH CARE	$5,000 or 100 visits (whichever is less) if Medi-Call approved	$5,000 or 100 visits (whichever is less) if Medi-Call approved	Plan pays 90% You pay 10%
HOSPICE CARE	$6,000 lifetime maximum, including $200 bereavement counseling	$6,000 lifetime maximum, including $200 bereavement counseling	Plan pays 90% You pay 10%
DURABLE MEDICAL EQUIPMENT	Plan pays 75% You pay 25% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	$5,000 maximum Plan pays 90% You pay 10%
ROUTINE MAMMOGRAPHY SCREENING	Ages 35 through 74 in participating facilities only; guidelines apply	Ages 35 through 74 in participating facilities only; guidelines apply	Plan pays 100%; guidelines apply
PAP TEST	Ages 18 through 65 routine or diagnostic	Ages 18 through 65 routine or diagnostic	Routine: any age; 2 per year; $15 copay. Diagnostic: copay/coinsurance
AMBULANCE	Plan pays 75% You pay 25% with coinsurance maximum for emergency transport	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	Plan pays 90% You pay 10%
EYEGLASSES/ HEARING AID	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program.	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program.	One exam for glasses or contacts per year ($45 copay for contacts exam). One pair glasses every other year (from designated selection).

[1]Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room, general nursing and miscellaneous hospital services and supplies.

and Dependents NOT Entitled to Medicare (cont.)

	HMO WITH POINT OF SERVICE (POS) OPTION			
CIGNA HMO	COMPANION-CHOICES POS		MUSC Options	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Plan pays 80% You pay 20% with $500 copay and coinsurance maximum	Plan pays 90% You pay 10% with $200 copay and coinsurance maximum	Plan pays 70% You pay 30% with $250 copay and coinsurance maximum	Plan pays 100% You pay $300 copay	Plan pays 60% You pay 40% with coinsurance maximum
Plan pays 80% You pay 20% up to 180 days	Plan pays 90% You pay 10% up to 120 days	Covered in-network only	Plan pays 100% up to $6,000 or 60 days, whichever is less	Plan pays 60% You pay 40% subject to deductible
Plan pays 100%	Plan pays 90% You pay 10% up to 60 days	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100%	Covered in-network only
Plan pays 100% up to 60 visits	Plan pays 90% You pay 10%	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100% up to $5,000 or 100 visits, whichever is less	Plan pays 60% You pay 40% subject to deductible
Not included	Plan pays 90% You pay 10%	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100% $6,000 lifetime maximum	Plan pays 60% You pay 40% subject to deductible
$3,500 maximum Plan pays 100%	$5,000 maximum Plan pays 90% You pay 10%	Covered in-network only	Plan pays 100%	Covered in-network only
Plan pays 100%	Plan pays 100%; guidelines apply	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100%	Covered in-network only
Plan pays 100% You pay $40 copay	Routine: any age; 2 per year; $15 copay. Diagnostic: copay/ coinsurance	Covered in-network only	Routine: any age; 2 per year; $15 copay. Diagnostic: copay/ coinsurance	Covered in-network only
Plan pays 80% You pay 20%	Plan pays 90% You pay 10%	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100%	Plan pays 60% You pay 40% subject to deductible
One exam every two years ($10 copay). Must use participating provider.	One exam for glasses or contacts per year ($45 copay for contacts exam). One pair glasses every other year (from designated selection).	Covered in-network only	Plan pays up to $75 for routine eye exam once per benefit period Plan pays up to $75 for eyewear once every other per benefit period	

Comparison of Health Plan Benefits for

TYPE			PPO To receive a higher level of benefits, subscribers should choose an in-network provider
PLAN	**MEDICARE**	**MEDICARE SUPPLEMENTAL**	**SHP STANDARD PLAN**
SERVICE AREAS	United States (Contact Medicare for information about services outside the United States)	Same as Medicare	Coverage worldwide
CANCELLATION POLICY	None	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums
ANNUAL DEDUCTIBLE	Part A: $876 (per benefit period) Part B: $100	Pays Medicare Part A and Part B deductibles	$350 (single) $700 (family) Carve-out method applies
PER OCCURRENCE DEDUCTIBLE	Inpatient hospital: Part A deductible ($876 per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home health care, durable medical equipment and VA hospital services)	Outpatient hospital: $75deductible Emergency care: $125 deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home health care, durable medical equipment and VA hospital services)
COINSURANCE	Part A: 100% Part B: 80% (you pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%
COINSURANCE MAXIMUM	None	None	$2,000 (single) $4,000 (family) (excludes deductible)
PHYSICIAN VISITS	Plan pays 80% You pay 20% Routine annual physicals and OB/GYN exams not covered	Plan pays Part B coinsurance of 20%	Carve-out method applies; $10 per visit deductible; Plan allows 80% in-network, 60% out-of-network Well child care visits & immunizations paid at 100% in-network to age 12
PRESCRIPTION DRUGS	No coverage, except for certain cancer drugs	Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): $23 generic, $56 preferred brand; $90 non-preferred brand Copaymnt Max: $2,500	Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): $23 generic, $56 preferred brand; $90 non-preferred brand Copayment Max: $2,500
MENTAL HEALTH/ SUBSTANCE ABUSE	Inpatient: Plan pays 100% for days 1-60 (Part A deductible applies); You pay $210/day for days 61-90; You pay $420/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days. Outpatient: Plan pays 50% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days (APS approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	Plan allows 80% (APS participating providers only if hospital stay exceeds 150 days) (carve-out method applies)
LIFETIME MAXIMUM	None	$1,000,000	$1,000,000

Retirees and Dependents Entitled to Medicare

TRADITIONAL HMO		HMO WITH POINT OF SERVICE (POS) OPTION	
All care must be directed by a primary care physician (PCP) and approved by the HMO.		To receive the higher level of benefits, care must be directed by a primary care physician (PCP) and approved by the HMO. Medically necessary benefits are available out-of-network at a lower benefit level.	
COMPANION HMO	**CIGNA HMO**	**COMPANION-CHOICES POS**	
Service areas: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	Service areas: 1, 2, 3, 5, 7, 8, 9, 10, 11, 12	Service areas: 1, 2	
Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	
Pays Medicare Part A and Part B deductibles	No deductible; Pays lesser of unreimbursed Medicare-allowed expense or plan's normal allowance	**In-network** Pays Medicare Part A and Part B deductibles	**Out-of-network** Pays Medicare Part A and Part B deductibles
Pays Medicare Part A deductible	Inpatient: $500 copay Outpatient facility: $250 copay Emergency care: $100 copay	Pays Medicare Part A deductible	Pays Medicare Part A deductible
Pays Part B coinsurance of 20%	Plan pays 80% or unreimbursed Medicare-allowed expense	Pays Part B coinsurance of 20%	Pays Part B coinsurance of 20%
None	$3,000 (single) $6,000 (family) (excludes certain copays)	None	None
Plan pays Part B coinsurance of 20%	$20 PCP copayment $40 OB/GYN well woman exam; $40 specialist copay Plan pays 80% or unreimbursed Medicare-allowed expense	Plan pays Part B coinsurance of 20%	Plan pays Part B coinsurance of 20%
Participating pharmacies only (Generics First): $7 generic $25 preferred brand $40 nonpreferred brand $75 specialty pharmaceuticals (31-day supply) Mail-order (up to 90-day supply): $21 generic; $75 preferred brand; $120 non-preferred brand No copayment Max	Participating pharmacies only: $10 generic $20 preferred brand $50 nonpreferred brand (30-day supply) Mail-order (up to 90-day supply): $20 generic; $40 preferred brand name; $100 non-preferred brand name No copayment Max	Participating pharmacies only (Generics First): $7 generic $25 preferred brand $40 nonpreferred brand $75 specialty pharmaceuticals (31-day supply) Mail-order (up to 90-day supply): $21 generic; $75 preferred brand; $120 non-preferred brand No copayment t Max	
Inpatient: Plan pays Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days. Outpatient: Plan pays Medicare deductible, 50% coinsurance	Participating providers only. Inpatient: $500 copay; Outpatient: $40specialist copay Plan pays 80% or unreimbursed Medicare-allowed expense.	Inpatient: Plan pays Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	
$1,000,000	$1,000,000	$1,000,000	

Comparison of Health Plan Benefits for Retirees

			PPO
PLAN	**MEDICARE**	**MEDICARE SUPPLEMENTAL**	**SHP STANDARD PLAN**
INPATIENT HOSPITAL DAYS[1]	Plan pays 100% for days 1-60 (Part A deductible applies); You pay $219/day for days 61-90; You pay $438/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days.	Plan pays: Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required)	Plan allows 80% (carve-out method applies) (Call Medi-Call if hospital stay exceeds 150 days)
SKILLED NURSING CARE	Plan pays 100% for days 1-20; You pay $109.50 for days 21-100	Plan pays $105 for days 21-100; Plan pays 100% beyond 100 days (Medi-Call approval required)	Plan allows 80% (carve-out method applies), up to $6,000 or 60 days, whichever is less. (Call Medi-Call if hospital stay exceeds 100 days)
PRIVATE DUTY NURSING	Not covered	$200 annual deductible Plan pays 80% if Medi-Call approved You pay 20% $5,000 annual max./$25,000 lifetime	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call approval required)
HOME HEALTH CARE	Plan pays 100%	Medi-Call available to assist with referrals	Plan allows 80% (carve-out applies) You pay 20% up to $5,000 or 100 visits, whichever is less
HOSPICE CARE	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals
DURABLE MEDICAL EQUIPMENT	Plan pays 80% (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Plan allows 80% (carve-out applies) (Medi-Call approval required)
ROUTINE MAMMOGRAPHY SCREENING	Age 40 and older, one every year Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Ages 35 through 74 in participating facilities only; guidelines apply
PAP TEST	Routine every two years (yearly if high risk) Plan pays 100% for Pap test Plan pays 80% for exam	Plan pays 20% coinsurance. Otherwise, pays routine ages 18 through 65 routine or diagnostic; diagnostic only age 66 and older	Routine yearly ages 18 through 65 routine; diagnostic only age 66 and older; Plan allows 100% for Pap test (carve-out applies when Medicare pays)
AMBULANCE	Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Plan allows 80% (carve-out method applies)
EYEGLASSES/ HEARING AID	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program

[1]Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room,general nursing and miscellaneous hospital services and supplies.

and Dependents Entitled to Medicare (cont.)

	TRADITIONAL HMO		HMO WITH POINT OF SERVICE (POS) OPTION	
	COMPANION HMO	CIGNA HMO	COMPANION-CHOICES	
	Plan pays: Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days	Plan pays 80% or unreimbursed Medicare-allowed expense after $500 copay	**In-network** Plan pays: Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days	**Out-of-network** Plan pays: Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days
	Plan pays $105 for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays 80% or unreimbursed Medicare-allowed expense, up to 180 days	Plan pays $105 for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays $105 for days 21-100; Plan pays 100% beyond 100 days
	Plan pays 80%; You pay 20% and $200 annual deductible $5,000 annual max./$25,000 lifetime (limited to 120 days)	Plan pays 100%	Plan pays 80%; You pay 20% and $200 annual deductible $5,000 annual max./$25,000 lifetime (limited to 120 days)	Plan pays 80% ; You pay 20% and $200 annual deductible $5,000 annual max./$25,000 lifetime
	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expense, up to 60 visits	(Medicare pays 100% of covered charges)	(Medicare pays 100% of covered charges)
	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expense	(Medicare pays 100% of covered charges)	(Medicare pays 100% of covered charges)
	Plan pays 20% coinsurance	$3,500 maximum Plan pays 100% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance
	Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance
	Plan pays 20% coinsurance. Otherwise, pays routine any age; 2 per year; $15. Diagnostic: copay/coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expense after $25 copay	Plan pays 20% coinsurance. Otherwise, pays routine any age; 2 per year; $15. Diagnostic: copay/coinsurance	Plan pays 20% coinsurance. Otherwise, covered in-network only
	Plan pays 20% coinsurance	Plan pays 90% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance
	One exam for glasses or contacts per year ($45 copay for contacts exam). One pair glasses every other year (from designated selection)	One exam every two years ($10 copay). Must use participating provider.	Plan pays up to $75 for routine eye exam once per benefit period Plan pays up to $75 for eyewear once every other per benefit period	